**Health and Human Resources Transition Report**

"An organization is uniquely designed to get the results that it gets."[1]

*"Large-scale social change requires broad cross-sector coordination, yet the social sectorremains* focused *on* the isol*ated intervention of individual organizations"*[2]

## Introduction

The structure of the Health and Human Resources Secretariat in Virginia includes 11 agencies as shown in figure 1. These agencies traditionally function as silos. The challenge this presents is that our citizens do not fit into our organizational and program structures. A recipient of services might be a child who must be considered in the context of a family structure, who in turn must be considered in the context of a community. Family structures and community structures are highly variable and in some cases largely absent. In this situation, the programs have been developed largely by federal design to address specific issues.

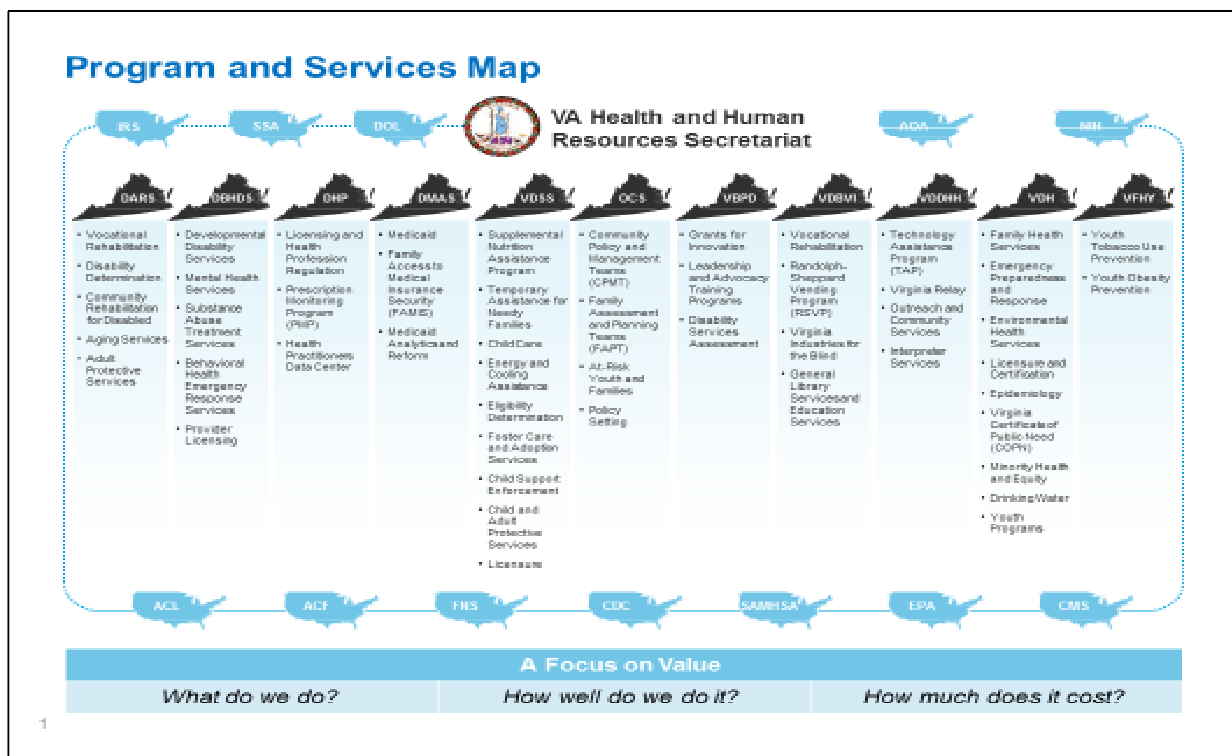


Figure 1

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[1] Dr. Paul Batalden

[2] John Kania & Mark Kramer, Stanford Social Innovation Review Winter 2011

According to the Stanford Social Innovation Review in Winter 2011, the United States ranked 18th of 24 industrialized nations in high school graduation rates, with more than one million drop-outs each year despite the large number of organizations and enormous amount of money spent on education. The need for coordination and collaboration was emphasized and the concept of **collective impact** was espoused as a potential solution. Collective impact lays out 5 conditions that must be met to optimize outcomes (see Figure 2).

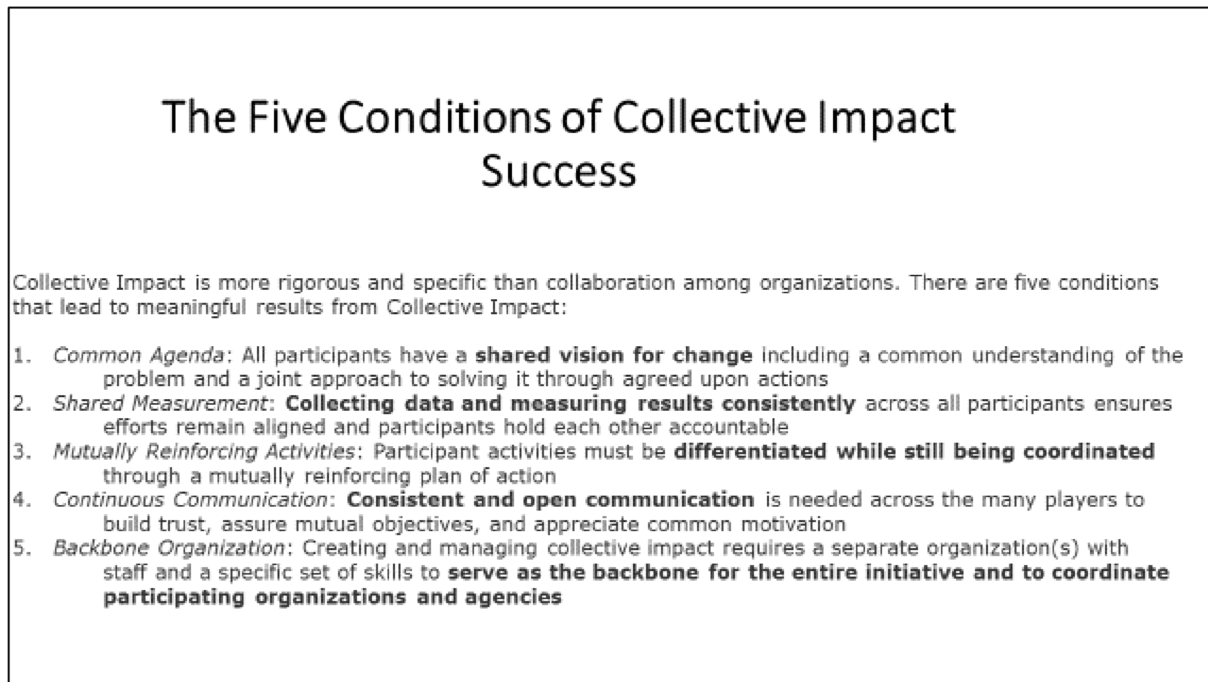



Figure 2

**The Challenges**

The challenge for HHR is not only the number of agencies but also the complexity of the federal, state, and local interactions, as well as the dependence on non-governmental agencies and organizations to provide services. Virtually all services are provided locally, and there is tremendous variation in capacity to provide and oversee these services. Figure 3 provides visualization of this complex delivery system. Absent common goals and meaningful exchange of information as well as the ability to measure outcomes, there is little ability to work collaboratively toward common goals. These shortcomings are manifest in many ways in the Commonwealth. The poor alignment of funding and oversight in behavioral health is just one example of this.

HHR Leadership began a strategic planning process in 2010 in an effort to begin the alignment of objectives. Several iterations of this process have provided a common set of objectives (Figure 4) and the publication of the "Plan for Well-Being" (http://virginiawellbeing.com/) offers some concrete goals for collective impact at the local and state level. It is hoped that communities would identify those goals that are most relevant to them and use them in discussions of "public benefit" with their not-for-profit agencies.

Figure 3

**Plan for Well Being**

The Plan for Well Being was led by the Virginia Department of Health and funded by the Virginia Center for Health Innovation through a State Innovation Model Grant. The Plan recognized that success in life and good health are not based entirely on genetics but also on factors termed nationally the "Social Determinants of Health". We refer to them as the social determinants for life. They range from having a safe place to live, to adequate nutrition and exercise, to having opportunities for gainful employment. Current practice is to provide support for individuals who have developed almost intractable problems; without a shift toward addressing these issues early on in a preventive fashion, there will be little ability to encourage personal responsibility and productivity and to reduce taxpayer spending in the future.

In that vein, pediatric medical literature has recognized that children exposed to a number of conditions such as poverty, abuse and neglect, homelessness or housing instability, incarceration of a parent, and substance abuse in the household will develop behavioral and physical illnesses. Recent studies show that nonphysical forces change brain development as a child grows. While some children are more resilient than others, these permanent physical and physiological changes in brain functioning have significant implications for success in life.

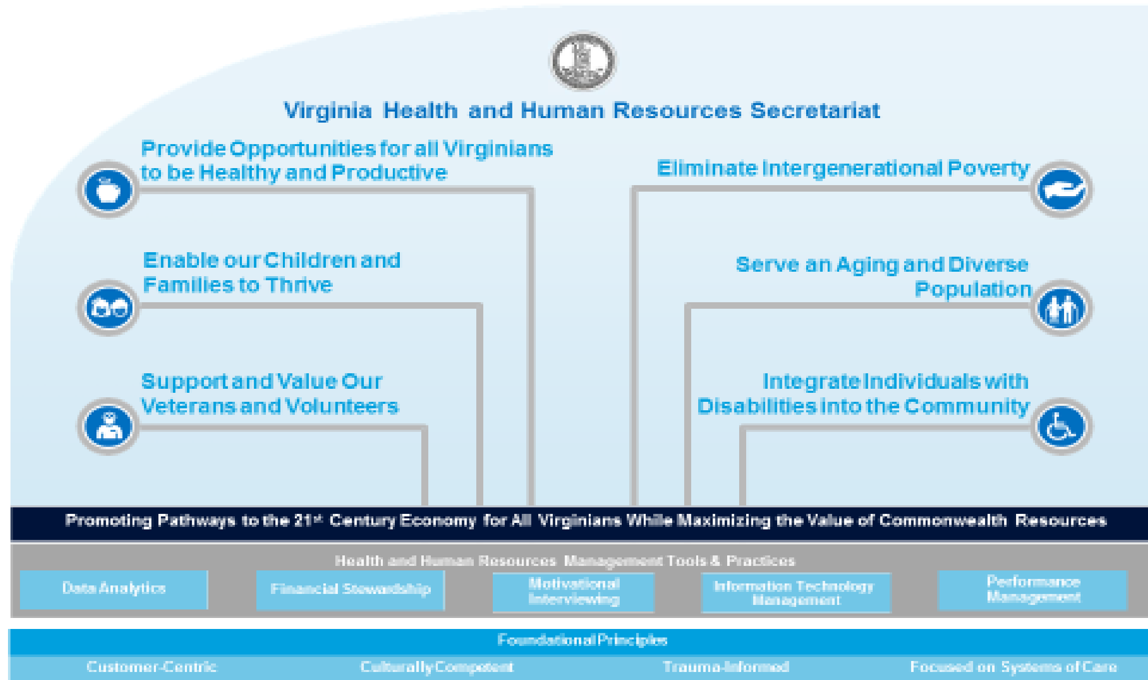



Figure 4

Individuals are often enrolled in multiple programs within the Secretariat. A recent study of enrollment in just five programs administered by the Virginia Department of Social Services documents the number of individuals who are enrolled in multiple programs. (Figure 5) Of the 2,662,747 individuals enrolled in Medicaid, SNAP, TANF, Child Protective Services, and Family Services, 929,260 received benefits in more than one program.

**Member Overlap Analysis**

| Source | No. of Members | # of Members with Overlaps | % of Members with Overlaps | Count in CPS | % in CPS | Count in FC | % in FC | Count in FS | % in FS | Count in MA | % in MA | Count in TANF | % in TANF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CPS | 47,403 | 31,256 | 66 | 47,403 | 100 | 503 | 1 | 26,759 | 56 | 29,893 | 63 | 7,291 | 15 |
| FC | 2,553 | 2,366 | 93 | 503 | 20 | 2,553 | 100 | 979 | 38 | 2,288 | 90 | 325 | 13 |
| FS | 1,211,982 | 853,134 | 70 | 26,759 | 2 | 979 | 0 | 1,211,982 | 100 | 844,697 | 70 | 111,711 | 9 |
| MA | 1,283,516 | 855,060 | 67 | 29,893 | 2 | 2,288 | 0 | 844,697 | 66 | 1,283,516 | 100 | 109,435 | 9 |
| TANF | 117,293 | 116,703 | 99 | 7,291 | 6 | 325 | 0 | 111,711 | 95 | 109,435 | 93 | 117,293 | 100 |

- Total Members (including duplicates) = 2,662,747
- Total Members with Overlaps = (1,858,519 / 2) = 929,260

From the perspective of assisting individuals and families, the variability of eligibility standards and lack of integration of the programs creates significant barriers to overcoming the challenges that cause them to require the benefits (Figure 5) and services. This variability also adds expense as the state manages eligibility and increases case work due to the inability to share information between programs for these programmatic purposes.

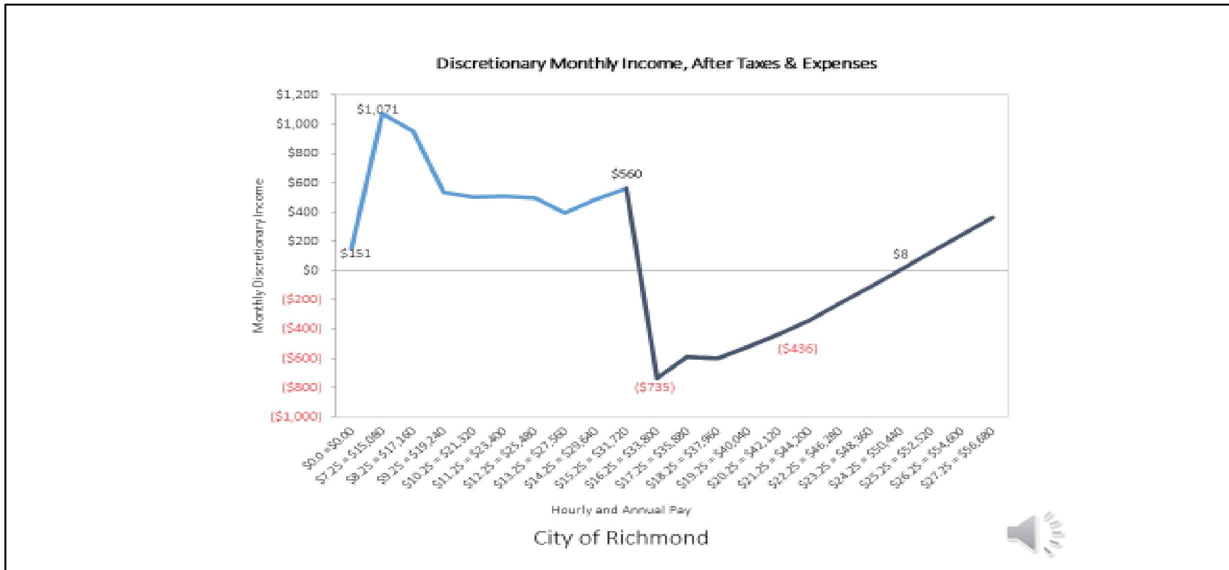



Figure 5

Figure 5 demonstrates that as this single mother of two in Richmond increases her income, the loss of benefits outweighs her additional pay. Note that she participates in seven separate programs (HUD Section 8 Voucher, SNAP, TANF, Medicaid, Childcare, School Lunch, and WIC) that are managed separately. This does not include the federal Earned Income Tax Credit or local programs.

The goal of HHR has been to migrate from a program-based system to a citizen-centric approach (Figure 6). While many individuals require “safety-net” support for a period of time, there are significant numbers of individuals who are high users of resources. It is necessary to consider the delivery of services differently for these more complicated cases. Often there are issues related to mental health, addiction, and/or disability. When individuals are involved in the justice system, these cases become even more complicated. In these situations, the coordination must extend beyond the HHR agencies.

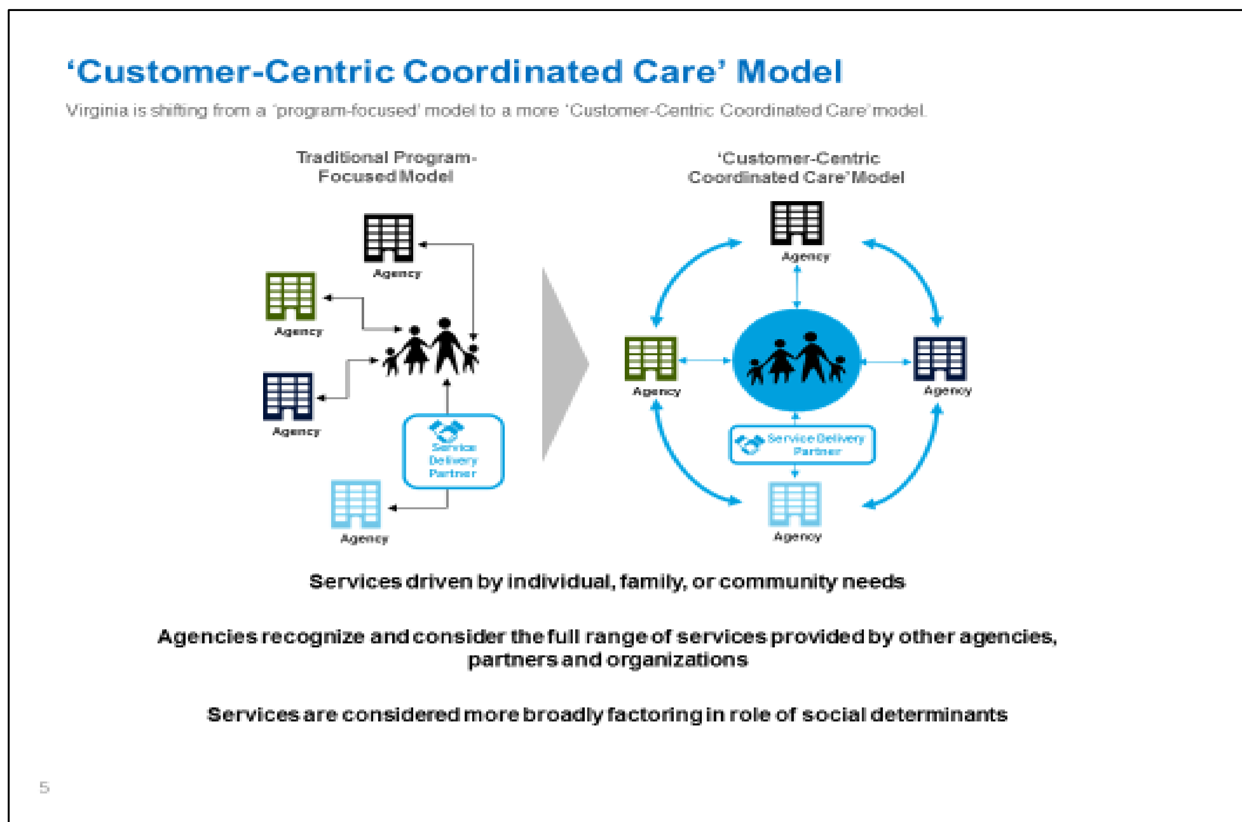



Figure 6

**The Value Equation is HHR**

The only consistent evaluation of HHR programs currently is by agency budgeting. The challenge is that all that is measured are the expenses incurred by each program. There has been almost no effort to look across systems to assess the costs to society incurred by not addressing the problems that are faced in HHR.

For instance, it is possible to know how much is spent to support jails, but it is not possible today to understand the costs to society of an individual with addiction. In addition to the potential issue of family disruption leading to Child Protective Services (CPS) intervention, there are compounding (potentially criminal) factors that lead to that disruption. For mothers who are addicted, a baby may be born with neonatal abstinence syndrome (or fetal alcohol syndrome), or she may have committed crimes in support of her habit. This means that in addition to the costs incurred by the social service and health systems, there are a number of uncalculated costs as a result of her interaction with law enforcement and potential jail sentences. Jail or prison is rarely the final destination, so the cycle perpetuates itself after release. The value of community services cannot be seen simply in the funds allocated toward these services.

Last year, the Virginia Early Childhood Foundation commissioned a study to review the funding for services for children age 1 to 5. The study revealed that more than $460 million is spent on this population, exclusive of Medicaid. Without looking across the programs, this analysis would not have been possible. Now that this analysis is available, does this change the way that these programs should function? Can they be held to aligned goals such as pre-K readiness?

For children above age 5, would school performance be better if attention to the resources currently being invested were aligned to actually support the goal of improving school performance? How would we know if it did or did not? Would it save resources in the school systems?

Likewise, would resources used to intervene early with youth reduce the numbers that become engaged with the juvenile justice system?

To know the answers, data must be shared not only across HHR agencies but also across secretariats and with localities and especially the school systems.

Current statute dating back to 1974 inhibits our ability to readily demonstrate the value of the programs and must be addressed. Additionally, resources must be provided to permit the analysis that is required to support policy making and budgeting. States as varied as South Carolina and Washington can serve as models for Virginia. Given the potential for federal block grants, it will become even more necessary to have useful information from across systems. Currently, we have a body with no brain.

**HHR activities that should be continued after transition**

There are several ongoing activities at the cabinet level that are intended to encourage and support collective impact. These are at greatest risk of being lost during a transition. Additionally, absent a consistent demand for performance management and staff development, there is risk of regression.

1) The initiative to manage the **addiction/opiate crisis** is led by the Secretaries of Public Safety and Homeland Security and Health and Human Resources. Agencies engaged in fighting this epidemic include the Virginia State Police, the Department of Criminal Justice Services, the Department of Health Professions (including the Prescription Monitoring Program), the Department of Forensic Services, the Virginia Department of Health, the Department of Medical Assistance Services, and the Department of Behavioral Health and Developmental Services. Local law enforcement and court engagement is essential. Federal support is enormous. This is a collective impact opportunity given the numbers of agencies at the state and local level that are involved. There is no short term fix, so it is essential that there be a mandate and resources made available as well as the ability to share data to continue to combat this scourge.

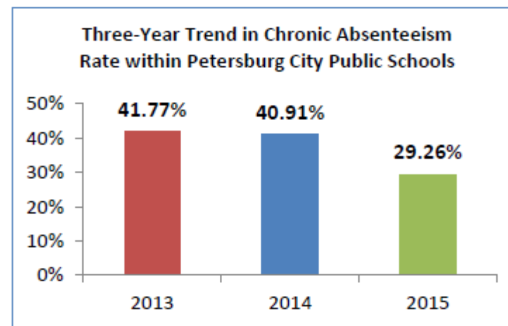
2) Last year, the **Center for Behavioral Health and Justice** was created as an outgrowth of the Governor's Task Force for Improving Mental Health Services and Crisis Response and pre-dated the recent issues in Hampton Roads. It's well known that jails, especially regional jails, have become a source of services for individuals with mental illness, addiction, and intellectual disabilities. Continued collaboration regarding diversion from the criminal justice system when appropriate and for adequate services when individuals are incarcerated is essential. There must be a consistent set of expectations for treatment in communities, jail, and state hospital settings. In addition to establishing adequate oversight of all of these systems, the financing must be aligned. The "wrong pocket" problem means that investments by one party create savings for another party. Going forward, this must be addressed by the General Assembly.

3) HHR agencies are cooperating with school systems in regions with failing schools to improve school readiness, reduce absenteeism, and provide needed services in schools while addressing potential issues of inappropriate referrals and potential fraud. The Secretariats of Public Safety and Homeland Security and Education have been addressing the issues related to the high number of referrals to the Department of Juvenile Justice from the schools. Sharing of information is essential. HHR actively supports the Virginia Longitudinal Data System in an effort to document

the benefit or lack thereof of programs. Legislation and funding are required to encourage this effort. The critical aspect has been to have a coordinator to help maintain the alignment that is required using the collective impact approach.

The **Children's Cabinet** has facilitated an unprecedented level of cooperation among agencies in the education, HHR, public safety, and commerce and trade secretariats. Progress has been made in aligning services for at-risk youth between the Department of Juvenile Justice and the Department of Social Services.

*Collaboration among the Children's Cabinet, the Challenged Schools Interagency Liaison Team, and the Petersburg City and Schools Partnership to address chronic absenteeism in Petersburg schools saw a 25% reduction over 3 years.*




*Source:* Virginia Department of Education Student Record Collection
Data current as of September 20, 2016
*Note:* Chronic absenteeism is defined as missing 10% or more of school ye

4) The **Governor's Coordinating Council on Homelessness** was created under former Governor Robert F. McDonnell and continues within the current administration. Virginia has been a national leader in reducing homelessness through system transformation and coordinating policies among housing agencies, Continuums of Care, and services to veterans. Safe, stable housing has been demonstrated to reduce medical expenses, to help individuals stay in their communities instead of state facilities, and to enhance learning for k-12 students. Housing is essential for recovery from mental illness and addiction. Virginia became the first state to "functionally end veteran homelessness". This success can be attributed to using the collective impact model. The Governor's Coordinating Council has served as the "backbone infrastructure" that has created the opportunity for this success. Given that homelessness is a problem that will not disappear, it is important to maintain executive branch leadership in this area.

5) **IT Integration and Data Analytics** have been a major focus for HHR since 2011 due to federal requirements and funding for the new eligibility system for Medicaid. Virginia chose to use this opportunity to build an infrastructure that could replace obsolete technology and empower agencies to utilize data for evidence based decision making. Outdated Virginia statute and a culture of "siloing" has made progress in this area very difficult. A separate report on data governance has been written and submitted. It is essential that de-identified data be available for necessary program oversight, auditing, and outcomes research. Identified data should be used appropriately with privacy and security precautions to optimize the benefits of the programs as well as to reduce fraud and abuse and to promote data security. HHR should be regarded as a single agency for the purpose of data management. A model Memorandum of Understanding should be accepted for the purpose of sharing data under appropriate conditions with other agencies. Virginia has generated such a document (the Enhanced Memorandum of Understanding or eMOU), but other states have improved upon it and put it into use. The support and oversight of the General Assembly is essential to this effort going forward to ensure that data is used for appropriate public purposes. We recommend the creation of a public-private partnership with the

state’s research universities to encourage research that is trusted by the legislature and the Executive Branch to evaluate performance of programs and to identify innovative opportune ideas for improvement. One further issue is the need to have bidirectional data exchange with our localities. Services funded by the Commonwealth are generally provided through local agencies including school systems. To understand the effectiveness and efficiency of those services, it is critical that data be shared within appropriate safeguards for information security and privacy.

6) **Human resource policies and staffing levels** continue to threaten the effectiveness of all HHR programs. There are likely to be extensive leadership changes over the next 18 months associated with the transition. It will be necessary to double-encumber a number of positions for training purposes. Due to the very tight staffing structures in most agencies, there has been little opportunity for career and skill development activities. In several areas, our salaries are not competitive with the private sector.

    a. While we are fortunate to have committed individuals in positions, we have had some significant failures in hiring simply due to salary. The biggest and most immediate risk to the Commonwealth is the inability to hire and reduce turnover of patient care staff at our hospitals. The work is generally considered to be more dangerous than at the public safety facilities. In fact, the leading cause of appeals from sheriffs to HHR and DBHDS is to manage prisoners who have behavior issues. HHR is losing staff to jails, corrections, and to major retailers.
    b. The opposite issue to hiring and developing a strong staff is the issue of termination of employees for cause. The process of grievance and appeals is cumbersome and time-consuming. While it is important to protect an individual from an unfair action, it is also important to protect those who are doing their jobs well from having to deal with or shoulder the load of misbehaving or underperforming colleagues.

7) **Health System Understanding and Oversight** in the executive branch is limited by the lack of capacity to evaluate the impact of state and federal policy on the non-public health system. While many components of the system are in HHR agencies, the oversight of insurers rests with the SEC. Data collection is a function for the Virginia Department of Health and the All-Payers Claims Database. Virginia’s State Employee Health Plan can drive improvements in the health system simply by the size of the contracts. The Joint Commission on Health Care of the General Assembly frequently asks for information regarding the economic impact of health policy that the executive branch does not have the capacity to model. Washington State has taken a next step and created a Health Authority to coordinate healthcare purchasing done by the state.

**Recommendations**

Many recommendations are implicit in the body of this report. The five major requests are:

1) Organize oversight, especially in the appropriations and finance areas, by issue areas instead of by agencies and;
    a. Establish budgets around the issue area.
    b. Establish the costs to the Commonwealth that are not recognized in the usual budgeting process, (i.e. the unfunded mandates on our families and localities.)
    c. Maximize efforts to align economic incentives between agencies as well as state and local partners. Cost shifting and cost savings are not the same.

2) Support executive branch functions that are needed to accomplish cross-Secretariat and cross-agency collaboration and the coordination that is required for better outcomes. With a one-term Governor, the knowledge and capacity for this activity is minimized.

3) Continue to demand privacy and security of protected information but make allowances so that the outcomes can be improved and value added for the taxpayer. A program purpose should include those that are allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and include determination of eligibility for the benefit, provision of service, oversight of the service, payment of the service, auditing of the program, and assessment of the program. Virginia must establish a common understanding of and culture around data sharing that includes our localities. The General Assembly should invest in creating model guidelines and memoranda of understanding so that each exchange of information does not require duplicative review.

4) Establish a health economics center in the executive branch or as a public-private partnership to analyze the impacts of policy and budget decisions on the private as well as the public system.

5) Ensure that the agencies continue to be able to convey;
    a. What they do;
    b. What success is for each program;
    c. How success is measured; and
    d. What the comprehensive costs are to the Commonwealth.